



2012 HEALTH FORM

STUDENT AMBASSADOR PROGRAMS

To respond to the individual needs of our Ambassadors, the delegate's parent or guardian is required to complete the following health form. **Submit it directly to the leader by January 15.** All information is confidential and may only be released to People to People program staff. In the event of an emergency, information provided can be given to the appropriate medical authority.

Program _____ Today's date _____

Delegate name _____ Delegate ID# _____

Delegate address _____
address city state/province zip code/postal code country

Phone (_____) _____ Date of birth ____/____/____ Gender ☐ Male ☐ Female

Does your child currently have any of the following conditions or symptoms?

An acute medical issue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe vision impairment (not corrected by glasses or contacts)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures or epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe hearing impairment (not corrected by hearing aids/implants)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobility limitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychological conditions (e.g. depression, mood disorders, anxiety, eating disorders, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Behavioral conditions (e.g. ADD, ADHD, ODD, PDD, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to any of the above items, please explain below. *(Please use additional page if necessary)*

Condition	Detailed description
_____	_____
_____	_____
_____	_____
_____	_____

Medications

Describe in detail any medications or treatment your child will be using while on the program. None ☐

Medication	Reason	Medication	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Describe in detail any medications or treatment your child will be using while on the program. None ☐

Allergy	Reaction	Medication required	Life-threatening?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

For allergic emergencies, my child carries auto-injectable epinephrine (e.g., *Epipen*®). ☐ Yes ☐ No

Dietary requirements

Please understand that we cannot guarantee certain meal requests, but please note any special needs. None ☐

form continues on opposite side

Delegate name _____ Delegate ID# _____

Additional description of relevant health conditions:

Emergency contact information

Emergency contact name _____ Relationship to delegate _____

Emergency contact phone: Home (_____) _____ Cell/other (_____) _____

Physician's name _____ Physician's phone number (_____) _____

In the highly unlikely event you need professional medical treatment during our program, please provide your insurance carrier information and sign the release listed below which allows the sharing of medical information with our People to People staff.

Name of insurance provider _____ Insurance contact phone number (_____) _____

Name of covered member _____ Identification number for delegate _____

Group number _____ RX group number if different _____

Please note: People to People Ambassador Programs highly recommends your child have a personal cell phone in case of an emergency. If your child plans to bring a cell phone, please provide the number here. (_____) _____

We require all delegates/guests participating in People to People Ambassador Programs to care for their recurring medical treatments without supervision. All medications, injections, or other treatments must be monitored and administered by the individual. Please understand we cannot control the contents of food products during travel. Should your child have dietary allergies, they are ultimately responsible for inspecting all food for ingredients related to the allergy.

Medical treatment, information sharing, and disclosure waiver

I _____, parent/or legal guardian of _____, do hereby give authorization to People to People Ambassador Programs and its representatives and agents, to seek and provide medical services for my child when deemed appropriate by your staff. I also give authorization to any medical facility and medical staff, to share personal medical information involving my child with any People to People Ambassador Programs staff and its representatives and agents accompanying my child.

At People to People Ambassador Programs we are proud of our ability to provide reasonable accommodations as required by law. We have limited ability to meet such needs when we are not made aware of a condition or need for an accommodation in advance. Therefore, failure to disclose a medical condition that would require any accommodation on this medical health form may result in our inability to provide the accommodation. Should a delegate arrive on one of our programs without first disclosing such a need, it is understood that the delegate may be returned home at the sole expense of the delegate's parent/guardian.

Signature (parent/guardian) _____ **Date** _____

Print name _____